UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA
Miami Division

[Filed September 15, 2003]

**MDL No. 1334**
**Master File No. 00-1334-MD-MORENO**

IN RE: MANAGED CARE LITIGATION

---

THIS DOCUMENT RELATES TO
**PROVIDER TRACK CASES**

---/

## ORDER GRANTING IN PART AND DENYING IN PART MOTIONS TO COMPEL ARBITRATION

Defendant managed care companies[1] seek to compel Plaintiff health care providers[2] to arbitrate all of their claims. Most of the Defendants have previously sought arbitration, and the

---

[1] The managed care companies include: UnitedHealthcare, Inc. and UnitedHealth Group Incorporated f/k/a United HealthCare Corporation ("United"), PacifiCare Health Systems, Inc. ("PacifiCare"), Health Net, Inc. f/k/a Foundation Health Systems, Inc. ("Health Net"), WellPoint Health Networks, Inc. ("WellPoint"), The Prudential Insurance Company of America, Humana, Inc., Humana Health Plan, Inc., Coventry Health Care, Inc. and Anthem, Inc. (collectively referred to as "Defendants" or "HMOs").

[2] The health care providers include: Doctors Charles B. Shane, Jeffrey Book, Michael Burgess, Edward L. Davis, Lance R. Goodman, H. Robert Harrison, Glenn L. Kelly, Leonard J. Klay, Eugene Mangieri, Kevin Molk, Martin Moran, Manuel Porth, Thomas Backer, David Boxstein, Susan Hansen, Andres Taleisnik, Julio Taleisnik, Roger Wilson and Navid Ghalambor, as well as Medical Associations from California, Texas, Georgia, Florida, Louisiana and Denton County [Texas] (collectively referred to as "Plaintiffs" or "Providers").

Court has twice determined which claims had to be resolved through arbitration. *In re Managed Care Litig.*, 143 F. Supp. 2d 1371 (S.D. Fla. 2001); *In re Managed Care Litig.*, 132 F. Supp. 2d 989 (S.D. Fla. 2000). These decisions were affirmed in their entirety by the United States Court of Appeals for the Eleventh Circuit. *In re Humana Inc. Managed Care Litig.*, 285 F.3d 971 (11th Cir. 2002). However, the Supreme Court reversed in part, concluding that arbitration should be compelled despite certain contractual provisions prohibiting the arbitral award of punitive damages. *PacifiCare Health Sys., Inc. v. Book*, 123 S. Ct. 1531 (2003). More specifically, the Supreme Court held that Providers could be compelled to arbitrate their claims under the Racketeer Influenced and Corrupt Organization Act, 18 U.S.C. § 1961 *et seq.* ("RICO"), even though certain arbitration agreements could be construed to limit the arbitrator's authority to award treble damages. While the First and Second Arbitration Orders were up on appeal, Providers filed a Second Amended, Consolidated Class Action Complaint **(D.E. No. 1607)** (the "Complaint") modifying their claims and adding new Defendants in the "Main Track."[3] The new Defendants seek arbitration while the past Defendants renew their motions to compel arbitration. For the reasons outlined *infra*, the various motions to compel arbitration are GRANTED in part and DENIED in part consistent with this opinion.

---

[3] There also are numerous "tag along" cases that have been transferred to this Court by the Judicial Panel on Multi-District Litigation. All such tag-along cases are temporarily stayed pending disposition of dispositive motions in the Main Track. *See* Order Staying Provider Track Tag-Along Cases **(D.E. No. 2264)**, filed on **August 21, 2003**.

## I. INTRODUCTION

### *A. The Complaint*

The Complaint alleges ten separate causes of action: (i) conspiracy to commit RICO violations, 18 U.S.C. § 1962(d); (ii) aiding and abetting RICO violations, 18 U.S.C. § 2 ((i) and (ii) collectively referred to as "derivative RICO claims"); (iii) so-called "direct" RICO violations, 18 U.S.C. § 1962(a) & (c); (iv) RICO declaratory and injunctive relief, 18 U.S.C. § 1964(a); (v) breach of contract; (vi) unjust enrichment/constructive contract; (vii) violation of various state prompt pay statutes; (viii) violation of the California Business & Professions Code § 17200; (ix) violation of the Connecticut Unfair Trade Practices Act; and (x) violation of the New Jersey Consumer Fraud Act.

### *B. Procedural Background*

The complaint at the time of the appeal as well as this Court's prior rulings were succinctly summarized by the Eleventh Circuit:

> In this case, a group of doctors, acting on behalf of themselves and others similarly situated, have sued several HMOs on various grounds—including RICO, ERISA, quantum meruit, breach of contract, federal clean claim payment regulations, unjust enrichment, and state prompt pay statutes. The suit is made particularly complicated by the wide array of different relationships among the various parties in the action, relationships that we need not elaborate here beyond noting the following: some of the doctors had contracts with some of the HMOs; some of those contracts had arbitration clauses; and some of those arbitration clauses placed limitations on the sort of damages an arbitrator may award. The task facing the district court was, in short, to determine which of the various legal claims must be resolved through arbitration.

> The district court made four rulings related to this appeal. First, the court held that claims between plaintiffs and defendants who are both signatories to contracts containing enforceable arbitration clauses must be arbitrated. Second, relying primarily on our opinion in *Paladino v. Avnet Computer Technologies, Inc.*, 134 F.3d 1054 (11th Cir. 1998), the court found that those arbitration clauses that exclude punitive damages are unenforceable in this suit because they preclude recovery of treble damages under RICO; therefore, an HMO may not compel arbitration of a RICO suit under such an arbitration clause. Third, the court determined that an HMO may not invoke its arbitration clause to compel arbitration of an aiding-and-abetting charge regarding a doctor's contractual rights with a different HMO. Fourth, the court held that exceptions to the general rule that a non-party to a contract may not invoke the contract—exceptions we described in *MS Dealer Corp. v. Franklin*, 177 F.3d 942 (11th Cir. 1999)—do not apply in the present case; thus an HMO that is not a signatory to a particular contract may not invoke that contract's arbitration clause to compel arbitration.

*In re Humana Inc. Managed Care Litig.*, 285 F.3d at 973.[4]

The Court also made several additional rulings in the First and Second Arbitration Orders that are relevant to resolution of the instant disputes. First, arbitration generally is limited to claims made pursuant to particular contracts during the effective dates of those contracts. *In re Managed Care Litig.*,

---

[4] While United argues that the Court's previous ruling that it may not compel arbitration of derivative RICO claims that stem from contractual relationships with other managed care companies was based *solely* on the perceived infirmities arising from remedial limitations, the Court did not need to reach the broader issue as to United at that time. Regardless, the rationale of the broader ruling applicable to the other Defendants, as reaffirmed in the Second Arbitration Order, is equally applicable to United.

143 F. Supp. 2d at 1374. Second, a physician whose contract with a company's subsidiary contains an arbitration agreement must arbitrate any claims against the parent company even though the physician's direct contractual relationship is with the subsidiary. *In re Managed Care Litig.*, 132 F. Supp. 2d at 996-97, 1000 n.3, 1002 n.6, 1005 n.9. Similarly, a physician whose work was performed through a separate practice group must arbitrate any claims made pursuant to the group's contract with the health plan.[5] *Id.* Third, cost distribution provisions are not a sufficient hurdle to enforcement of arbitration clauses executed by "sophisticated groups of doctors" like Providers who "contract to provide health care to large groups of patients." *Id.* at 998. Finally, a one year statute of limitations to bring claims in arbitration upon written notice is not alone enough to preclude arbitration. *See id.* at 1000-01. Furthermore, as discussed more fully *infra* in Sections II and III(A)(2), *Howsam v. Dean Witter Reynolds, Inc.*, 537 U.S. 79 (2002), probably requires both notice and cost distribution provisions to be construed by an arbitrator in the first instance, since such clauses implicate questions of procedural not substantive arbitrability.

## II. LEGAL STANDARD

The Federal Arbitration Act (the "FAA") extends to the furthest reaches of Congress's Commerce Power and is applicable as long as the contract at issue *affects* interstate commerce. 9 U.S.C. § 2 ("contract evidencing a transaction involving commerce"); *Allied-Bruce Terminix Cos. v. Dobson*, 513 U.S. 265, 273-74 (1995); *Toledo v. Kaiser Permanente Med. Group*, 987 F. Supp. 1174, 1180 (N.D. Cal. 1997) (applying applicable standard in managed care context). There

[5] The First Arbitration Order bound physicians to arbitration agreements executed by affiliated practice groups. The Court now reaches the same conclusion as to hospital, foundation and other similar agreements by logical extension.

is no dispute that the contracts at issue affect interstate commerce.

"A party aggrieved by the alleged failure, neglect or refusal of another to arbitrate under a written agreement for arbitration may petition any United States district court . . . for an order directing that such arbitration proceed in the manner provided for in such agreement. . . . [T]he court shall make an order directing the parties to proceed to arbitration in accordance with the terms of the agreement." 9 U.S.C. § 4. The FAA establishes a strong federal policy, even a presumption, in favor of arbitration. *Moses H. Cone Mem'l Hosp. v. Mercury Contr. Corp.*, 460 U.S. 1, 24-25 (1983). If Providers' allegations "touch matters" covered by the relevant arbitration agreements, then those claims must be arbitrated, irrespective of how the allegations are labeled. *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 625 n.13 (1985). Whether a matter is within the scope of an arbitration provision is a matter of the parties' intent, and "those intentions are generously construed as to issues of arbitrability." *Id.* at 626. Courts decide this threshold issue of substantive arbitrability unless there is "clear and unmistakable evidence" that the parties intended to submit such questions to an arbitrator. *Dean Witter Reynolds, Inc. v. Fleury*, 138 F.3d 1339, 1342-43 (11th Cir. 1998) (citing *First Options of Chicago, Inc. v. Kaplan*, 514 U.S. 938, 943 (1995)).

Even though there is a strong federal policy favoring it, arbitration is a matter of contract, and parties can only be required to submit disputes to arbitration if they agreed to do so. *First Options*, 514 U.S. at 942-43; *AT&T Techs., Inc. v. Communications Workers of Am.*, 475 U.S. 643, 648-49 (1986); *United Steelworkers of Am. v. Warrior & Gulf Nav. Co.*, 363 U.S. 574, 582 (1960). An arbitration agreement "shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any

contract." 9 U.S.C. § 2. "[A]lthough federal law establishes the enforceability of arbitration agreements, a court must construe that agreement according to generally applicable principles of state law." *In re S.E. Banking Corp.*, 156 F.3d 1114, 1121 n.9 (11th Cir. 1998) (citing *Perry v. Thomas*, 482 U.S. 483, 492 n.9 (1987)); *Eassa Props. v. Shearson Lehman Bros., Inc.*, 851 F.2d 1301, 1304 n.7 (11th Cir. 1988) ("While federal law may govern the interpretation and enforcement of a valid arbitration agreement, state law governs the question of whether such an agreement exists in the first instance."). Accordingly, "courts are not to twist the language of the contract to achieve a result which is favored by the federal policy but contrary to the intent of the parties." *Goldberg v. Bear Sterns & Co.*, 912 F.2d 1418, 1419-20 (11th Cir. 1990).

Therefore, the Court must determine whether an applicable agreement to arbitrate exists and, if so, whether the disputes at issue are within the scope of the parties' agreement to arbitrate. 9 U.S.C. § 4; *Howsam*, 537 U.S. at 83-85; *Mitsubishi*, 473 U.S. at 626-28. All other issues should be resolved by the arbitrator in the first instance, including the impact of any notice provisions, statutes of limitation, cost distribution provisions or remedial limitations. *PacifiCare*, 123 S. Ct. at 1535-36; *Howsam*, 537 U.S. at 83-85.

## III. DISCUSSION

The Court previously has issued two arbitration orders in the Provider Track as well as one arbitration order in the related Subscriber Track.[6] At the risk of falling into the category of which Ralph Waldo Emerson wrote about when he stated that "a foolish consistency is the hobgoblin of small minds," the Court will not re-examine its previous rulings,

---

[6] The Subscriber Track involves related claims of Defendants' insureds. All claims in the Main Subscriber Track have been dismissed, and only one Subscriber Track tag-along case remains pending for adjudication before this Court.

except to the extent that they are decisively impacted by the Supreme Court's decisions this past term in *PacifiCare* and *Howsam*, significant new facts or altered circumstances. As detailed below, the Court finds that *PacifiCare* and *Howsam*, as well as the purported fundamentally different allegations in the latest Complaint, do not require the Court to digress from any of its previous rulings, the lone exception being the impact of potential remedial limitations on the arbitrability of RICO claims. For instance, and perhaps most importantly, the Court declines to reconsider its decision not to apply the principles of *MS Dealer* to Providers' derivative RICO claims. This ruling was affirmed by the Eleventh Circuit and the "new" allegations in the Complaint as well as the new argument proffered by both old and new Defendants does not alter the result. PacifiCare is the most vociferous proponent of a reexamination of the applicability of *MS Dealer*. However, the Court rejects the argument that the balance of equities has changed with the filing of the final Complaint and that entities that have only marginal connection to PacifiCare should not be able to thwart arbitration by alleging a unitary conspiracy.

In addition to affirming the applicability of its previous rulings to all Defendants, both old and new, the Court also must consider several new issues and arguments. The Court first addresses certain general topics relevant to most, if not all, Defendants, including: (i) the arbitrability of "direct" RICO claims after *PacifiCare;* (ii) the continued nonarbitrability of derivative RICO claims under the Complaint; (iii) the fate of non-participating provider claims ("non-par claims"); (iv) the viability of claims asserted by medical associations; and (v) the impact of certain broad arbitration provisions on claims not made pursuant to the particular agreements containing such clauses. Second, the Court briefly addresses the applicability of these general rulings to the individual Defendants. To this end, the Court incorpo-

rates by reference four "arbitration charts" filed by the parties and sets out a supplemental briefing schedule concerning the applicability of the Court's rulings to the specific parties, claims and contracts remaining in the Main Track. Finally, the Court summarily considers the numerous motions to stay or dismiss pending arbitration.

### *A. Topics Common to Multiple Defendants*

#### 1. Remedial Limitations Clauses

*Paladino* is no longer authoritative as to direct RICO claims after the Supreme Court's decisions in *PacifiCare* and *Howsam*. Thus, all direct RICO claims that stem from contractual relationships subject to arbitration must be arbitrated, notwithstanding any clauses limiting the availability of punitive, exemplary or extra-contractual damages. It is for the arbitrator to decide in the first instance whether any applicable provisions improperly limit the availability of treble damages. This ruling also necessarily applies to derivative RICO claims that stem from contractual relationships with the target Defendant, as opposed to contractual relationships with other managed care companies. Moreover, such logic also extends to state law causes of action that support recovery of punitive, exemplary, extra-contractual or treble damages. *See also Mastrobuono v. Shearson Lehman Hutton, Inc.*, 514 U.S. 52, 58 (1995); *Davis v. Prudential Sec., Inc.*, 59 F.3d 1186, 1192 n.6 (11th Cir. 1995); *Bonar v. Dean Witter Reynolds, Inc.*, 835 F.2d 1378, 1387 n.16 (11th Cir. 1988). Thus, all remedial limitations provisions must be construed by arbitrators in the first instance.

#### 2. Derivative RICO Claims

While Providers' focus undoubtedly has morphed over time, this category of claims remains largely shielded from arbitration. The Court previously held that derivative RICO claims against a particular Defendant based upon contractual relationships with other managed care companies are not sub-

ject to arbitration. The Court also previously held that Defendants may not borrow co-Defendants' arbitration clauses under the principles of *MS Dealer*. The Eleventh Circuit has affirmed both holdings. As discussed more fully below, the Court finds that neither *PacifiCare* or *Howsam* nor the alleged changed circumstances require the Court to amend its previous rulings.

Defendants first argue that *PacifiCare* mandates arbitration of these claims. However, contrary to Defendants' pleas, *PacifiCare* does not directly require arbitration of Providers' RICO conspiracy and aiding and abetting claims that stem from contractual relationships with other managed care companies. Even though the Supreme Court did not differentiate between direct and derivative RICO claims in its introductory description, its substantive analysis only expressly addresses the impact of United and PacifiCare's remedial limitations. Moreover, the question framed by the Supreme Court militates in favor of the Court's conclusion: "In this case, we are asked to decide whether respondents can be compelled to arbitrate claims arising under [RICO], notwithstanding the fact that the parties' arbitration agreements may be construed to limit the arbitrator's authority to award damages under that statute." *PacifiCare*, 123 S. Ct. at 1533. Simply put, the Supreme Court never separately analyzed the fate of Defendants' derivative RICO claims. While Defendants' requested ruling certainly may be a logical *extension* of the Supreme Court's decision, the Court cannot depart from its previous rulings without express direction from an appellate court. Finally, the Court declines the parties' invitations to divine from the appellate "litigation history" rulings beyond those contained within the four corners of the opinions from the Eleventh Circuit and the Supreme Court.

Defendants also argue that *Howsam* calls into question the Court's decision as to derivative RICO claims. The Court again disagrees. *Howsam* addressed the question of who

should decide whether a claim was barred by the limitation provisions of the National Association of Securities Dealers Code of Arbitration. The Supreme Court held that gateway questions that grow out of the dispute itself and bear upon its final disposition should be decided by arbitrators *(e.g.* statute of limitations), but that true questions of substantive arbitrability relating to whether the parties contractually agreed to arbitrate the dispute *(e.g.* existence of a contract) are for the court to decide. *Howsam*, 537 U.S. at 84-85. Thus, questions concerning whether a nonsignatory can invoke an arbitration agreement, or whether a given dispute is within the scope of a particular arbitration clause, are for the district court to decide. Notwithstanding the above, the Court acknowledges that *Howsam* eliminates any lingering doubt as to who should decide the effect of notice provisions, statutes of limitation and cost distribution provisions.

Third, in light of the specific allegations cited and the new Defendants named in the Complaint, Defendants argue that certain arbitration provisions are broad enough to capture particular Provider's derivative RICO claims that stem from contractual relationships with other managed care companies. This argument is premised upon the "touch matters" standard articulated by relevant arbitration case law. *AT&T Techs., Inc. v. Communications Workers of Am.*, 475 U.S. 643, 648-49 (1986); *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 625 n. 13 (1985); *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24-25 (1983). So the argument goes, because the Court cannot determine with "positive assurance" that such arbitration clauses are not susceptible to an interpretation that covers the asserted disputes, it has no choice but to compel arbitration of these claims. Defendants assert that there is no exception to the mandated inquiry for conspiracy allegations. *J.J. Ryan & Sons, Inc. v. Rhone Poulenc Textile, S.A.*, 863 F.2d 315, 321-22 (4th Cir. 1988). They argue that claims may simultane-

ously "touch matters" within the scope of an arbitration agreement and "stem from" agreements with other Defendants.

Defendants further maintain that the Complaint clarifies that *all* RICO claims are predicated on proof that each HMO committed direct RICO violations and that the most recent complaints differ "dramatically" from previous versions considered by the Court. For instance, Defendants assert that it is now clear that all RICO claims are inextricably intertwined, because the "new" allegations clarify that Defendants needed to act in concert for their fraudulent schemes to be successful and that the goal of the conspiracy is to keep one's own doctors under contract, as opposed to an altruistic motive to help another Defendant. *See* Complaint ¶ 118 ("[F]or the fraudulent schemes described above to be successful, each Defendant and other members of the conspiracy had to agree to enact and utilize the same devices and fraudulent tactics against the Plaintiffs and the members of the class. If only one Defendant engaged in these activities, physicians would and could refuse to do business with that Defendant, but together Defendants have the power and influence necessary to effect and perpetuate their scheme."). While Defendants insist that this type of language simply was not present when the Court issued the First Arbitration Order, the Court notes that the Second Arbitration Order considered similar language in the Amended, Class Action Consolidated Complaint ¶¶ 198-201.

The Eleventh Circuit addressed this issue when it stated that "an HMO may not invoke its arbitration clause to compel arbitration of an aiding-and-abetting charge regarding a doctor's contractual rights with a different HMO." *In re Humana Inc. Managed Care Litig.*, 285 F.3d at 973. Even if the Eleventh Circuit had not addressed this issue, the Court finds that the "new" allegations do not require alteration of its previous decision. It is undisputed that the basic conspiracy allegations have been in the complaint since the beginning of

this case, *i.e.* that each Defendant agreed with each other to develop and deploy certain automated processing techniques to cheat doctors and agreed to use it on their own doctors. Simply put, the "new" allegations differ more in degree than kind. Also, Paragraph 118 of the Complaint can be construed merely as an allegation of motive, as opposed to a core allegation of conspiracy.

Moreover, the Court believes that even the broadest of arbitration provisions at issue in this case, *i.e.* those covering "all grievances and disputes" and claims "related to" the contract, do not contemplate the capture of the contracting Defendants' conspiracy with or aid to another Defendant's violation of its contractual agreements. A common sense interpretation of the arbitration clauses at issue limits them to disputes over the practices of the contracting parties, not the contracting Defendants' assistance with other Defendants' breaches, even if one of the motives was to preserve their own ability to harm the contracting Providers. While noteworthy, the alleged interconnected nature of the claims is not dispositive. *See Hill v. G.E. Power Sys., Inc.*, 282 F.3d 343, 347 (5th Cir. 2002); *see also Howsam*, 537 U.S. at 83-84; *Mitsubishi*, 473 U.S. at 627-28; *Prima Paint Corp. v. Flood & Conklin Mfg. Co.*, 388 U.S. 395, 403-04 (1967).

**3. Non-Par Claims**

The prior complaints did *not* include claims by non-participating providers. Non-participating providers, by definition, do not have a written contractual relationship with the target HMO. To complicate matters, Providers allege that some doctors have both contract and non-contract claims *(i.e.* are both participating and non-participating providers) as to some Defendants. The primary question concerns whether these claims are legally linked to assignments of the underlying subscriber claims for benefits. If so, the assignee-providers "stand in the shoes" of the assignor-subscribers, including their obligation to arbitrate. *Misic v. Building Serv.*

*Employees Health & Welfare Trust*, 789 F.2d 1374, 1378 (9th Cir. 1986); *see also Cagle v. Bruner*, 112 F.3d 1510, 1514-15 (11th Cir. 1997). These claims can be divided into two camps: claims by doctors that have *no* contractual relationship with the target Defendant and those by doctors that do have such a contractual relationship, but also allege non-par claims.

As for the latter, Defendants again advance their scope argument. In those circumstances in which there is a contract between a Provider and a particular Defendant establishing a commercial relationship, Defendants argue that the scope of that contractual agreement combined with its arbitration clause is sufficient to encompass whatever non-par claims for payment that same Provider may be bringing as to that Defendant. *AT&T*, 475 U.S. at 648-49; *Mitsubishi*, 473 U.S. at 625 n.13; *Cone*, 460 U.S. at 24-25. While several Defendants advance isolated provisions of particular contracts that they claim evidence that the scope of these contracts with their arbitration clauses are broader than the particular subscribers, networks, plans or covered services specifically addressed, the Court again finds that a common sense interpretation of these contracts limits their applicability to such specific subscribers, networks, plans and services. While recognizing that this is a closer question than in the derivative RICO claim context, the Court nonetheless finds that even the broadest arbitration clauses at issue are limited to claims made pursuant to the contracts in which such clauses are contained.

The presence of a boilerplate integration clause does not alter this analysis. For instance, if a contract covers the rendition of services to particular subscribers for particular services, even the broadest arbitration clauses ("all grievances and disputes" or "related to" language) do not encompass non-par or other out-of-network claims, regardless of whether such claims arose before or after the effective date of the

contract at issue. While Defendants assert that such niceties are for the arbitrator to decide under *Howsam*, the Court believes that this inquiry is within the core substantive arbitrability determination for the Court. This finding is consistent with the Court's previous rulings limiting the scope of arbitration clauses to the particular contracts in which they are contained when a doctor has multiple contracts with a particular Defendant.

In the alternative, and as to those doctors without any enforceable arbitration clauses or without arbitration clauses of sufficient scope to encompass non-par claims with a particular Defendant, Defendants argue that Providers are bound by the terms of the evidence of coverage or other operative contract between the patient and the insurer, including any arbitration clauses. In support of this assertion, Defendants cite "hornbook" contract law, *Int'l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411(4th Cir. 2000) and *Sunkist Soft Drinks, Inc. v. Sunkist Growers, Inc.*, 10 F.3d 753 (11th Cir. 1993), *cert. denied*, 513 U.S. 869 (1994) (finding that a claim which presumes the existence of a licensing agreement subject to arbitration must be submitted to arbitration even if it does not rely exclusively upon the licensing agreement).

Defendants argue that Providers are seeking to advance claims that are necessarily derivative of, inextricably intertwined with, or presume the existence of a contract, be it through assignment, beneficiary principles or estoppel principles. Therefore, any claim for payment is necessarily derivative of the patient's insurance rights, especially since Providers are only asserting claims for covered services. *See* Complaint ¶ 4 ("The fundamental premise of the relationship between the Defendants and the doctors who treat their insureds, either pursuant to or without contract, is that the doctors will be paid in a timely manner for the *covered*

medically necessary services that they render.") (emphasis added).

This issue can be divided into those claims based on assignment theory and those asserted on non-contract grounds. In practice, doctors either (i) accept assignments and attempt to get payment directly from the insurance company, or (ii) administer claims paperwork as a courtesy but continue to hold patients liable for payment. As to assignment-based claims, there is no dispute that such claims must be arbitrated if the underlying subscriber is subject to an applicable and enforceable arbitration clause. Under this theory, Providers' claims only exist based upon the contractual right of the subscriber to seek benefits for the Providers' services. *Weiner v. Klais & Co.*, 108 F.3d 86, 92 (6th Cir. 1997). Thus, if the subscriber-assignor is subject to mandatory arbitration, the provider-assignee is required to submit such claims to arbitration. *Bel-Ray Co. v. Chemrite, Ltd.*, 181 F.3d 435, 444-46 (3d Cir. 1999); *Fisser v. Int'l Bank*, 282 F.2d 231, 233 n.6 (2d Cir. 1960); *see* also *Banque de Paris et des Pays-Bas v. Amoco Oil Co.*, 573 F. Supp. 1464, 1469-70 (S.D.N.Y. 1983). Otherwise, an assignor could give greater rights than they owned and deprive the other original party of contractual arbitration rights.

The inquiry is more difficult in the absence of an assignment theory. As correctly pointed out by Providers, these claims theoretically are independent of any contractual obligations of subscribers, since the relevant causes of action include unjust enrichment and various federal and state statutory claims. *Media Servs. Group, Inc. v. Bay Cities Communications, Inc.*, 237 F.3d 1326, 1330-31 (11th Cir. 2001); *In re De Laurentiis Entm't Group, Inc.*, 963 F.2d 1269, 1272 (9th Cir. 1992), *cert. denied*, 506 U.S. 918 (1992). While Defendants point out that recovery is only possible for services covered under subscriber contracts, and that such contract reliance necessarily requires adherence to any req-

uisite alternative dispute mechanisms, Providers clearly attempt to articulate claims independent of *any* contractual relationship. They assert that HMOs, which cannot have doctors in every geographic location and in every specialty, make it known through various sources that doctors will be reimbursed if they provide medically necessary services to their patients, even if they do not have a contract with the HMO. Moreover, such treatment often occurs in contexts where inspection of the coverage scope of applicable subscriber contracts is not feasible. Accordingly, the Court declines to compel arbitration of these non-par claims that are purportedly advanced independent of the particular subscriber contracts. While Defendants also argue that Providers lack standing to assert such claims, and that such claims are in any event preempted by ERISA, the Court will embark on that journey in the context of the various pending motions to dismiss.

Therefore, the Court will not compel non-par claims to arbitration in the absence of an agreement to do so. Any Provider claims that are based upon assignments from subscribers with arbitration clauses must be arbitrated. Moreover, any Provider claims that necessarily rely upon subscriber contracts with arbitration clauses also must be arbitrated. All other Provider claims that rely upon non-contractual or quasi-contractual state statutes or common law theories of recovery, and that are independent of any subscriber contractual relationship, are not arbitrable. As mentioned above, the Court will further examine the viability of such causes of action in the context of the pending motions to dismiss.

**4. <u>Medical Associations</u>**

The next important decision concerns the fate of the claims pressed by the various Plaintiff medical associations. These medical associations have brought suit for declaratory and injunctive relief both individually and on behalf of their

respective memberships. Analysis of this issue can be neatly divided into alleged direct and derivative claims.

Associations suing in a representative capacity generally are bound by the same limitations and obligations as the members that they represent. *Hunt v. Wash. St. Apple Adver. Comm'n*, 432 U.S. 333, 342-43 (1977) (citing *Warth v. Seldin*, 422 U.S. 490, 511 (1975)); *Communications Workers of Am. v. AT&T Co.*, 40 F.3d 426, 434 n.2, 435 (D.C. Cir. 1994) (dismissing union's claims because its members did not exhaust administrative remedies or submit dispute to mandatory arbitration). In fact, Defendants argue that associations are bound by the greatest commitments of the least of their physicians; otherwise, it would permit those physicians to escape their commitments merely by having a representative sue on their behalf. *Crow Tribe of Indians v. Campbell Farming Corp.*, 828 F. Supp. 1468, 1478 (D. Mont. 1992), *aff'd*, 31 F.3d 768 (9th Cir. 1994), *cert. denied*, 514 U.S. 1018 (1995). However, because numerous associational members are not bound by enforceable arbitration clauses with respect to the claims brought, Providers attempt to bring suit only on behalf of their members that are not bound by enforceable arbitration clauses. In support, Providers argue that the *Hunt* standing factors are the sole requirements in this context and that they need only identify one member with standing. *Sea Shore Corp. v. Sullivan*, 158 F.3d 51, 55 (1st Cir. 1998).

Nonetheless, the Court finds that the issue of standing is at least partially distinct from whether the association must arbitrate its representative claims. Associations may not pick and chose the members that they represent; otherwise, they *de facto* avoid the requirements of Fed. R. Civ. P. 23. *See Crow Tribe*, 828 F. Supp. at 1478. Moreover, the logic of *Warth* is that prospective relief is the only remedy that "will inure to the benefit of those members of the association actually injured." *Warth*, 422 U.S. at 515. An association that abandons some of its allegedly injured members no longer pur-

ports to be a "representative" of its membership. Instead, it attempts to act as a *de facto* class aggregator of selected members and seek prospective injunctive relief that would benefit all of its membership.

Furthermore, partial representation would violate the prudential standing requirements articulated in the third prong of the *Hunt* test. *Hunt*, 432 U.S. at 343 (holding that claims asserted and relief requested must not require individual participation in the lawsuit); *see also Rent Stabilization Ass'n v. Dinkins*, 5 F.3d 591, 596 (2d Cir. 1993). The Article III requirement that at least one association member must have individual standing is separate from the prudential requirement that an association can only sue when it can obtain prospective relief on behalf of all of its allegedly injured members. *United Food & Comm. Workers Union Local 751 v. Brown Group, Inc.*, 517 U.S. 544, 555-57 (1996). In the instant case, participation of individual members is unavoidable. The only way for the Court to determine which members have claims not subject to arbitration and what prospective relief might be appropriate for those members is for each member to participate and defend against a motion to compel arbitration. *See generally Kan. Health Care Ass'n, Inc. v. Kan. Dep't of Social & Rehab. Serv.*, 958 F.2d 1018, 1022-23 (10th Cir. 1992).

Because the Court has ruled that many of the pending claims of individual Providers must be submitted to arbitration, it is inevitable that certain of each of the associations' members are required to arbitrate the claims raised on their behalf. The Court also notes that Providers have made no attempt to distinguish which associational members are free from enforceable arbitration clauses. Accordingly, all arbitrable claims asserted on behalf of memberships at least partially subject to enforceable arbitration clauses must be submitted to arbitration. Of course, any nonarbitrable claims brought derivatively by medical associations, including the deriva-

tive RICO and non-par claims addressed *supra* in Section III(A)(2) and (3), remain pending before this Court.

Several associations also contend that they have standing in their own right to bring the asserted claims. *Conn. St. Med. Soc'y v. Connecticare, Inc.*, No. X01 CV 010165649S, 2002 WL 725510 (Conn. Super. Ct. Apr. 1, 2002) (finding that a medical society had independent standing to bring claims for injunctive relief under state unfair trade practices statute). "An organization also has standing to sue for relief from injury to its own interests, apart from any injury to its members, since standing may be established in an individual or representative capacity." *Id.* at *3 (quotations omitted); *see also Havens Realty Corp. v. Coleman*, 455 U.S. 363, 378-79 (1982). Associations generally have independent standing if they have direct injury. *Ragin v. Harry Macklowe Real Estate Co.*, 6 F.3d 898, 904-05 (2d Cir. 1993); *Spann v. Colonial Village, Inc.*, 899 F.2d 24, 27 (D.C. Cir. 1990), *cert. denied*, 498 U.S. 980 (1990), 498 U.S. 1046 (1991); *Village of Bellwood v. Dwivedi*, 895 F.2d 1521, 1526 (7th Cir. 1990); *Pac. Legal Found. v. Goyan*, 664 F.2d 1221, 1224 (4th Cir. 1981). In short, these associations argue that they have expended their own resources to fight Defendants' alleged unlawful practices and have lost members due to these practices. Because the associational Defendants themselves are not subject to enforceable arbitration clauses, this issue will best be resolved in the context of motions to dismiss for standing, not motions to compel arbitration.

**5. Multiple Contracts and Effective Dates**

Finally, the Court examines Defendants' argument that certain arbitration clauses, most notably those that apply to "all grievances or disputes" or anything that "relates to" the particular contract, are broad enough to engulf claims not made or brought pursuant to the particular contracts containing these clauses. The Court hereby incorporates its rulings articulated *supra* in Section III(A)(2) and (3) as to Defen-

dants' scope argument in the context of derivative RICO and non-par claims. In this vein, the Court also incorporates its previous ruling that arbitration generally is limited to claims arising under or made pursuant to particular contracts during the effective date of those contracts. *In re Managed Care Litig.*, 143 F. Supp. 2d at 1374. Most notably, this issue arises in the context of claims by physicians having multiple contracts with particular Defendants and claims arising before or after the effective dates of particular contracts.

For instance, certain Defendants, including Health Net and WellPoint, seek to impose arbitration on claims performed pursuant to contracts without arbitration clauses and even outside the scope of *any* contract. Similarly, Anthem argues that Dr. Shane must arbitrate both claims arising *before* and after execution of his contracts. In support, these Defendants cite extremely broad arbitration clauses that purport to apply to "all grievances and disputes" between the parties or any claims "related to" the applicable agreements. Admittedly, some courts have held that broad arbitration clauses can cover claims arising under other agreements lacking arbitration provisions. *ARW Exploration Corp. v. Aguirre*, 45 F.3d 1455, 1462 (10th Cir. 1995), *cert. denied*, 525 U.S. 822 (1998); *Associated Brick Mason Contractors of Greater N.Y., Inc. v. Harrington*, 820 F.2d 31, 35-36 (2d Cir. 1987); *see also Inlandboatmens Union of Pac. v. Dutra Group*, 279 F.3d 1075, 1080 (9th Cir. 2002). Other courts have held that broad arbitration agreements can cover disputes that arose prior to execution of the agreement. *E.g., Zink v. Merrill Lynch Pierce Fenner & Smith, Inc.*, 13 F.3d 330, 332 (10th Cir. 1993); *Mail-Well Envelope v. Int'l Ass'n of Machinists & Aerospace Workers*, 916 F.2d 344, 346-48 (6th Cir. 1990); *Beneficial Nat'l Bank v. Payton*, 214 F. Supp. 2d 679, 689-90 (S.D. Miss. 2001); *Spurlock v. Life Ins. Co. of Va.*, No. CIV.A.98-D-222-N, 2000 WL 1785300, *8 (M.D. Ala. Oct. 31, 2000); *but see Peerless Imps., Inc. v. Wine, Liquor &*

*Distillery Workers Union Local One*, 903 F.3d 924, 927-28 (2d Cir. 1990); *Armada Coal Exp., Inc. v. Interbulk, Ltd.*, 726 F.2d 1566, 1567-68 (11th Cir. 1984).

However, arbitration clauses cannot be extended beyond the context that the parties intended. *ITT Hartford Life & Annuity Ins. Co. v. Amerishare Invests., Inc.*, 133 F.3d 664, 669-70 (8th Cir. 1998) (refusing to compel arbitration of suit to enforce guarantees via clause in separate agreement establishing underlying business relationship); *see also Frank v. Am. Gen. Fin., Inc.*, 23 F. Supp. 2d 1346, 1349 (S.D. Ala. 1998). Recognizing that this is a close call, the Court finds, consistent with its previous rulings and the analysis set forth above, that even the broadest arbitration clauses at issue do not contemplate claims not brought pursuant to the particular contract containing such clauses. A common sense interpretation of these provisions limits their application to the particular services specifically addressed by the heart of the contract, since the agreements as a whole relate to and concern the rights and liabilities of the parties within the context of that particular contractual relationship. Moreover, many of these contracts contain other clauses that appear to further restrict the scope of arbitrable disputes. Accordingly, the Court finds that the scope of the arbitration clauses at issue is limited to claims made pursuant to the particular contract containing such clauses. Finally, while Defendants continue to argue that arbitrators must decide these issues in the first instance, such scope determinations implicate substantive arbitrability and are therefore for the Court to decide.

### *B. Application to Individual Defendants*

The Court declines at this time to painstakingly apply its previous rulings in the First and Second Arbitration Orders (as modified by *PacifiCare)* as well as its new rulings in this Order to the numerous parties, claims and contracts remaining in this case. In response to the Court's previous rulings and the Supreme Court's *PacifiCare* decision, Providers vol-

untarily dismissed certain claims subject to arbitration. *See* Notice of Dismissal of Arbitrable Claims **(D.E. No. 1637),** filed on **October 10, 2002**; Supplemental Notice of Dismissal of Arbitrable Claims **(D.E. No. 1720),** filed on **November 15, 2002**; Notice of Dismissal of Arbitrable Direct RICO Claims Against PacifiCare and United **(D.E. No. 1945),** filed on **April 18, 2003**; Second Supplemental Notice of Dismissal of Arbitrable Claims **(D.E. No. 2281**), filed on **August 26, 2003**. At oral argument the parties also confirmed that "all direct claims that have been raised by a physician as to services performed pursuant to a contract with a Defendant containing an [enforceable] arbitration clause . . . includ[ing] any conspiracy or aiding and abetting claims as to that Defendant with respect to services performed under that contract . . . are dismissed." The Court anticipates further dismissals based upon this Order.

Accordingly, the Court reserves decision on the application of all relevant rulings to the particular parties, claims and contracts remaining in this case until further consultation and briefing by the parties. The Court also attaches and incorporates by reference four "arbitration charts" filed by the parties in an attempt to organize the remaining parties, claims and contracts containing arbitration provisions. *See* Providers' Main Track Arbitration Status Report **(D.E. No. 2278**), filed on **August 26, 2003** ("Appendix 1"); Defendants' Arbitration Chart Responsive to Court's 8/21/03 Order **(D.E. No. 2279),** filed on **August 26, 2003** ("Appendix 2"); Defendant Health Net, Inc.'s Notice of Supplemental Fling to Defendants' Arbitration Chart Responsive to Court's 8/21/03 Order **(D.E. No. 2280**), filed on **August 26, 2003** ("Appendix 3"); Providers' Notice of Filing Corrected Main Track Arbitration Chart **(D.E. No. 2323),** filed on **September 8, 2003** ("Appendix 4"). Thus, the parties are hereby directed to file supplemental briefing applying the relevant arbitration rulings to the remaining parties, claims and contracts outlined in the at-

tached arbitration charts, including any argument as to the enforceability of pertinent contracts. Defendants shall file initial briefing by no later than **September 29, 2003**. Providers shall file responsive briefing by no later than **October 15, 2003**. Defendants may reply by no later than **October 24, 2003**.

### *C. Motions to Stay*

"If any suit or proceeding be brought in any of the courts of the United States upon any issue referable to arbitration under an agreement in writing for such arbitration, the court in which such suit is pending, upon being satisfied that the issue involved in such suit or proceedings is referable to arbitration under such an agreement, shall on application of one of the parties stay the trial of the action until such arbitration has been had in accordance with the terms of the agreement, providing the applicant for the stay is not in default in proceeding with such arbitration." 9 U.S.C. § 3. Thus, all arbitrable claims are stayed pending adjudication in arbitration or dismissal by Providers. *Kotam Elecs., Inc. v. JBL Consumer Prods., Inc.*, 93 F.3d 724, 728 (11th Cir. 1996), *cert. denied*, 519 U.S. 1110 (1997).

On the other hand, all claims not subject to arbitration remain active before this Court. The Court has repeatedly refused to stay claims, as opposed to *issues*, not subject to arbitration. Simply put, the parties have not provided any new facts or argument that counsel against continued consistency with the Court's previous orders. Moreover, neither the Eleventh Circuit nor the Supreme Court has addressed the Court's refusal to stay nonarbitrable claims. Besides, Providers are not pursuing arbitrable claims, so no duplication of effort or preclusive effect is foreseeable, and the Court previously ruled that Defendants may not pursue dismissed claims under the guise of declaratory relief or otherwise. *See* Order Granting Plaintiffs' Motion to Enjoin Arbitration **(D.E. No. 1705),** filed on **November 6, 2002**; Order Denying

United's Motion to Strike Plaintiffs' Notice of Dismissal and for Involuntary Dismissal with Prejudice of Arbitrable Claims (**D.E. No, 1748**), filed on **November 25, 2002**.

## IV. CONCLUSION

THIS MATTER came before the Court upon Defendant PacifiCare Health Systems, Inc. and PacifiCare Operations, Inc.'s Notice of Renewal of Motions (**D.E. No. 693**), filed on **December 1, 2000**, Defendant PacifiCare Health Systems, Inc.'s Motion to Compel Arbitration as to Newly Added Plaintiffs (**D.E. No. 1130**), filed on **April 26, 2001**, Defendant The Prudential Insurance Company of America's Motion to Compel Plaintiffs to Arbitrate their Claims (**D.E. No. 1137**), filed on **April 27, 2001**, Defendant WellPoint Health Networks, Inc.'s Motion to Compel Arbitration (**D.E. No. 1158**), filed on **April 30, 2001**, Defendant Health Net, Inc.'s Motion to Compel Arbitration (**D.E. No. 1165**), filed on **April 30, 2001**, Defendant Humana Inc. and Humana Health Plan Inc.'s Motion to Compel Arbitration (**D.E. No. 1171**), filed on **April 30, 2001**, Defendant United's Motion to Compel Plaintiffs to Arbitrate their Claims and to Stay Proceedings Pending Arbitration (**D.E. No. 1182**), filed on **May 2, 2001**, Defendant PacifiCare Health Systems, Inc.'s Motion to Compel Arbitration of Plaintiffs' Conspiracy and Aiding-and-Abetting Claims based on their Arbitration Commitments with Other Defendants (**D.E. No. 1193**), filed on **May 4, 2001**, the Order to Show Cause Directed to Dr. Kelly (**D.E. No. 1199**), filed on **May 4, 2001**, Defendant Health Net, Inc.'s Motion to Reconsider this Court's Order of April 26, 2001, that Modified its Arbitration Order of December 11, 2000, Concerning Defendant Health Net (**D.E. No. 1207**), filed on **May 10, 2001**, Defendant Coventry Health Care, Inc.'s Motion to Compel Arbitration (**D.E. No. 1249**), filed on **June 8, 2001**, Defendant PacifiCare Health Systems, Inc.'s Motion to Compel Arbitration as to Plaintiffs Ghalambor and Hansen (**D.E. No. 1296**), filed on **June 26, 2001**, Defendant

Health Net, Inc.'s Motion to Compel Arbitration of the Claims Asserted by Navid Ghalambor, M.D. as a Participating Provider (**D.E. No. 1557**), filed on **August 16, 2002**, Defendant Health Net, Inc.'s Motion to Compel Arbitration of Any Claims Plaintiffs Navid Ghalambor, M.D., Susan Hansen, M.D., Andres Taleisnik, M.D., Julio Taleisnik, M.D., or Roger Wilson, M.D., may be Asserting Regarding Services Performed as Nonparticipating Providers (**D.E. No. 1558**), filed on **August 16, 2002**, Defendant PacifiCare Health Systems, Inc.'s Supplemental Motion to Compel Arbitra tion as to Plaintiffs Boxstein, Breen, Ghalambor, Klay, A. Taleisnik, J. Taleisnik and Wilson (**D.E. No. 1564**), filed on **August 16, 2002**, Defendant PacifiCare Health Systems, Inc.'s Joinder in Motion to Compel Arbitration of Co-Defendants (**D.E. No. 1565**), filed on **August 16, 2002**, Defendants UnitedHealthcare Inc. and UnitedHealth Group Incorporated's Motion to Strike Portions of Plaintiffs' Consolidated Amended Class Action Complaint Relating to Plaintiff Navid Ghalambor or, in the Alternative, Motion to Compel Arbitration as to Plaintiff Navid Ghalambor (**D.E. No. 1570**), filed on **August 16, 2002**, Defendants United Healthcare, Inc., UnitedHealth Group Incorporated f/k/a United HealthCare Corporation, United HealthCare Insurance Company, United HealthCare of Georgia, Inc., UnitedHealthcare of New Jersey, Inc., UnitedHealthcare of New York, Inc. And United HealthCare of Tennessee, Inc.'s Joinder in Motion to Compel Arbitration of Co-Defendants (**D.E. No. 1571**), filed on **August 16, 2002**, Defendant Coventry Health Care, Inc.'s Second Motion to Compel Arbitration (**D.E. No. 1649**), filed on **October 17, 2002**, Defendant Health Net, Inc.'s Notice of Renewal of its Motions to Compel Arbitration (**D.E. No. 1651**), filed on **October 18, 2002**, Defendants UnitedHealthcare, Inc. and UnitedHealth Group Incorporated f/k/a United HealthCare Corporation's Supplemental Motion to Dismiss and Notice of Renewal of its Motions to Compel Arbitration and to Stay Proceedings Pending Arbitration (**D.E. No. 1657**),

filed on **October 18, 2002,** Defendant WellPoint Health Networks, Inc.'s Motion to Compel Arbitration (**D.E. No. 1659**), filed on **October 18, 2002,** Defendant Anthem, Inc.'s Motion to Compel Arbitration (**D.E. No. 1666**), filed on **October 18, 2002**, Defendants Humana, Inc. and Humana Health Plan, Inc.'s Renewed Motion to Compel Arbitration (**D.E. No. 1668**), filed on **October 18, 2002,** Defendant PacifiCare Health Systems, Inc.'s Contingent Motion to Compel Arbitration (**D.E. No. 1717**), filed on **November 15, 2002,** Defendants United Healthcare, Inc. and UnitedHealth Group Incorporated f/k/a United HealthCare Corporation's Joinder in Defendant PacifiCare Health Systems, Inc.'s Contingent Motion to Compel Arbitration (**D.E. No. 1808**), filed on **December 18, 2002**, Defendants UnitedHealth Group Incorporated, UnitedHealthcare, Inc., and PacifiCare Health Systems, Inc.'s Renewal of their Motions to Compel Arbitration and to Stay Proceedings (**D.E. No. 1943**), filed on **April 17, 2003,** Defendants PacifiCare Health Systems, Inc., The Prudential Insurance Company of America, UnitedHealthcare, Inc., UnitedHealth Group Incorporated, Humana, Inc., Humana Health Plan, Inc., Health Net, Inc., Coventry Health Care, Inc., Anthem, Inc. and WellPoint Health Networks, Inc.'s Alternative Supplemental Motion to Dismiss Any Conspiracy or Aiding-and-Abetting Theories Related to the Direct RICO Claims that Plaintiffs have Renounced—or may be Expected to Renounce (**D.E. No. 1948**), filed on **April 21, 2003**, the Notice of Joinder of Defendants Anthem, Inc., Coventry Health Care, Inc., Health Net, Inc., Humana, Inc., Humana Health Plan, Inc., Prudential Insurance Company of America and WellPoint Health Networks, Inc. to UnitedHealth Group Incorporated, UnitedHealthcare, Inc. and PacifiCare Health Systems, Inc.'s Renewal of their Motions to Compel Arbitration (**D.E. No. 1956**), filed on **April 25, 2003,** and Defendants Humana, Inc. and Humana Health Plan, Inc.'s

Corrected Renewed Motion to Compel Arbitration (**D.E. No. 2247**), filed on **August 13, 2003**.[7]

THE COURT has considered the motions, the notices, the Order, the responses and the pertinent portions of the record, and being otherwise fully advised in the premises and in open court, it is

**ADJUDGED** that the motions to compel arbitration and motions to stay are GRANTED in part and DENIED in part consistent with the above opinion.

DONE AND ORDERED in Chambers at Miami, Florida, this 15th day of September, 2003.

s/ Federico A. Moreno
FEDERICO A. MORENO
UNITED STATES DISTRICT JUDGE

COPIES PROVIDED TO COUNSEL ON
THE **JULY 31, 2003** SERVICE LIST

[Omitted is the 139-page appendix of claims charts submitted by the parties in response to the district court's order of August 21, 2003.]

---

[7] The Court noticed oral argument on all pending motions to compel arbitration for August 14, 2003. *See* Order Setting Hearing and Requiring Notice of Pending Motions to Compel Arbitration (**D.E. No. 2122**), filed on **July 15, 2003**. The Court advised the parties that any Main Track motions to compel arbitration not brought to the attention of the Court by July 24, 2003, would be denied without prejudice as abandoned. In accordance with that Order, all Main Track motions to compel arbitration not listed above are DENIED without prejudice as abandoned.

[PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

[Filed November 5, 2004]

---

No. 03-14828

---

D. C. Docket No. 00-01334-MD-FAM

LEONARD J. KLAY, M.D., ALL PLAINTIFFS, PRICE PLAINTIFFS, PRICE, SESSA, KATZ & YINGLING, SANDRA JOHNSON, PATRICIA FREYRE, et al.,
Plaintiffs-Appellees,

REGINA JOI PRICE, et al.,
Plaintiffs,

versus

ALL DEFENDANTS, et al.,
Defendants,

PACIFICARE HEALTH SYSTEMS, INC., HUMANA, INC., COVENTRY HEALTH CARE, INC., ANTHEM HEALTH PLANS, INC., PRUDENTIAL INSURANCE COMPANY OF AMERICA, UNITED HEALTHCARE, UNITED HEALTH GROUP, HUMANA HEALTH PLAN, INC., WELLPOINT HEALTH NETWORKS, INC.,
Defendants-Appellants.

---

Appeal from the United States District Court
for the Southern District of Florida

---

(November 5, 2004)

Before ANDERSON and BIRCH, Circuit Judges, and LAND*, District Judge. BIRCH, Circuit Judge:

This appeal requires us to determine the propriety of a district court order in light of prior appeals and the scope to be afforded to broad arbitration clauses. Based on our previous rulings and existing precedent, the district court refused to compel arbitration of various claims asserted by plaintiffs-appellees and declined to stay litigation of nonarbitrable claims. Because we previously affirmed the district court's refusal to compel arbitration of RICO conspiracy and aiding and abetting claims in a decision not disturbed by the United States Supreme Court, the law of the case doctrine compels us to affirm the district court's order regarding these claims. With respect to the scope to be given to broad arbitration clauses, a matter not decided previously, we also affirm the district court's ruling that broad arbitration clauses cannot be extended to compel parties to arbitrate disputes they have not agreed to arbitrate.

## I. BACKGROUND

Plaintiffs-appellees, a group of physicians acting on behalf of themselves and others similarly situated ("physicians"), sued defendants-appellants, a collection of health maintenance organizations ("HMOs"), on various grounds—including violations of the Racketeer Influenced and Corrupt Organizations Act (RICO), breaches of various state prompt pay statutes, and claims for quantum meruit, breach of contract, and unjust enrichment. At bottom, the physicians alleged that the HMOs, individually and collectively by conspiring and aiding and abetting each other, failed to properly reimburse physicians for services rendered. Because the facts of this case have been detailed in prior opinions, see

---

* Honorable Clay D. Land, United States District Judge for the Middle District of Georgia, sitting by designation.

PacifiCare Health Sys., Inc. v. Book, 538 U.S. 401, 402-03, 123 S. Ct. 1531, 1533-34 (2003); In Re Humana Inc. Managed Care Litig., 285 F.3d 971, 973 (11th Cir. 2002); In Re Managed Care Litig., 132 F. Supp. 2d 989, 992 (S.D. Fla. 2000), we recount here only those facts relevant to this appeal.

The physicians' complaint alleged ten claims against HMOs: (1) conspiracy to commit RICO violations under 18 U.S.C. § 1962(d); (2) aiding and abetting RICO violations under 18 U.S.C. § 2;[1] (3) direct RICO violations under 18 U.S.C. §§ 1962 (a) and (c); (4) RICO declaratory and injunctive relief under 18 U.S.C. § 1964(a); (5) breach of contract; (6) unjust enrichment; (7) violations of various state prompt pay statutes; (8) violations of the California Business and Professional Code; (9) violations of the Connecticut Unfair Trade Act; and (10) violations of the New Jersey Consumer Fraud Act. In response, HMOs moved to compel arbitration of these claims pursuant to arbitration agreements that had been signed between some of the physicians and some of the HMOs. See In Re Humana Inc. Managed Care Litig., 285 F.3d at 973 & n.1 ("[S]ome of the doctors had contracts with some of the HMOs; some of those contracts had arbitration clauses."). In deciding which of physicians' claims must be arbitrated, the district court made four rulings:

> First, the court held that claims between plaintiffs and defendants who are both signatories to contracts containing enforceable arbitration clauses must be arbitrated. Second, relying primarily on our opinion in Paladino v. Avnet Computer Technologies, Inc., 134 F.3d 1054 (11th Cir. 1998), the court found that those arbitration clauses that exclude punitive dam-

---

[1] The claims of conspiracy to violate RICO and aiding and abetting RICO violations shall be collectively referred to as "indirect RICO claims."

> ages are unenforceable in this suit because they preclude recovery of treble damages under RICO; therefore, an HMO may not compel arbitration of a RICO suit under such an arbitration clause. Third, the court determined that an HMO may not invoke its arbitration clause to compel arbitration of an aiding-and-abetting charge regarding a doctor's contractual rights with a different HMO. Fourth, the court held that exceptions to the general rule that a non-party to a contract may not invoke the contract—exceptions we described in MS Dealer [Serv.] Corp. v. Franklin, 177 F.3d 942 (11th Cir. 1999)—do not apply in the present case; thus, an HMO that is not a signatory to a particular contract may not invoke that contract's arbitration clause to compel arbitration.

In Re Humana Inc. Managed Care Litig., 285 F.3d at 973 (footnotes omitted). On appeal, we "affirm[ed] in its entirety the district court's order for the reasons set forth in its comprehensive opinion found at 132 F. Supp. 2d 989 (S.D. Fla. 2000)." Id. at 973-74.

HMOs then appealed to the United States Supreme Court with respect to the district court's second finding, i.e. that HMOs could not compel arbitration of RICO claims if the arbitration clauses excluded punitive damages awards because such clauses were unenforceable.[2] The Supreme Court reversed our decision and held that whether punitive damages limitations in the arbitration clauses precluded an award of treble damages, and whether such a finding would render the arbitration agreements unenforceable, should be decided by an arbitrator in the first instance. PacifiCare Health Sys., Inc., 538 U.S. at 407. As a result, we remanded

---

[2] At oral argument, HMOs admitted that they only sought certiorari with respect to this issue and did not also appeal the district court's other rulings, some of which they challenge in this appeal.

this case to the district court "for further proceedings in accordance with the Supreme Court's decision." In Re Humana Inc. Managed Care Litig., 333 F.3d 1247, 1248 (11th Cir. 2003).

While the issue of the arbitrability of RICO claims in light of contractual punitive damages limitations was on appeal, the physicians amended their complaint to add two new defendants, twelve new physician-plaintiffs, and six new medical association plaintiffs. They also amended their complaint to clarify the general allegations of conspiracy found in their prior amended complaint.[3] Following our remand, HMOs again moved to compel arbitration based on the Supreme Court's PacifiCare opinion. The district court ruled that: (1) direct RICO claims must be arbitrated pursuant to PacifiCare regardless of damages limitations in the arbitration agreements; (2) indirect RICO claims remain nonarbitrable pursuant to prior decisions which had not been disturbed by PacifiCare; (3) nonparticipating provider claims

---

[3] The parties disagree about whether the physicians' amended complaint really averred anything new. HMOs admitted that the "amended complaint clarified plaintiffs' theory of RICO conspiracy and aiding-and-abetting liability." Appellants' Br. at 10-11 (emphasis added). HMOs argue, however, that the general allegations of conspiracy found in physicians' first amended complaint did not subsume the more specific allegations of conspiracy found in the second amended complaint, i.e. that because all HMOs were concertedly failing to reimburse physicians properly, they conspired to effectively deny physicians the option to decline rendering services for a particular HMO in favor of contracting with a competing HMO. See Appellants' Reply Br. at 21-22. The physicians disagree and point to similar language found in both amended complaints with respect to HMOs' conspiracy. See Appellee's Br. at 19-20. The district court agreed with the physicians. See In Re Managed Care Litig., __ F. Supp. 2d __, __ (S.D. Fla. Sept. 15, 2003) ("[T]he 'new' allegations differ more in degree than in kind."); see also Klay v. Humana, Inc., 382 F.3d 1241, 1241 n.1 (11th Cir. 2004) ("[T]he substance of the allegations is the same across all three of the plaintiffs' complaints.").

("non-par claims")[4] are nonarbitrable if raised by physicians in the absence of either (i) a contract between the physician and the HMO regarding the services from which the claim arose or (ii) an assignment to a physician of the claim by a subscriber who had a contract with the HMO; (4) claims asserted by medical associations are arbitrable only to the extent that the claims of their members, on whose behalf the medical associations are raising the claims, are arbitrable; (5) the range of arbitrable claims is limited to those claims which arose during the effective dates of the arbitration contracts; and (6) litigation of nonarbitrable claims pending before the district court would not be stayed pending arbitration of claims deemed arbitrable. See In Re Managed Care Litig., __ F. Supp. 2d __, __ (S.D. Fla. Sept. 15, 2003). On appeal, HMOs argue that the district court erred by not directing arbitration of all indirect RICO claims, non-par claims, medical association claims, and claims outside of the effective dates of relevant contracts containing arbitration clauses and by not granting a stay of litigation pending the resolution of arbitrable claims.

---

[4] These claims arise when a patient receives care from a physician who is outside of an HMO's network of preferred physicians. This means the physician does not have a contract with the HMO to provide services for that particular patient. When a patient receives care from an out-of-network physician, the physician can attempt to receive payment directly from the HMO as a courtesy to the patient or the physician can receive a direct assignment of the patient's contractual right to reimbursement from the HMO. Because the treating physician does not participate in the patient's plan, such claims for reimbursement are referred to as "non-par" claims. These claims become more complicated in this case because some doctors have both contractual and non-par claims against some HMOs depending on the coverage of the patient from whom the claim for reimbursement arose.

## II. DISCUSSION

Because the issue of the arbitrability of indirect RICO claims was decided in our prior opinion, we will address it first under law of the case principles. Second, we will address the district court's refusal to compel arbitration of certain non-par claims, medical association claims, and claims outside the effective dates of contracts. Third, we will review the district court's denial of a motion to stay of litigation of nonarbitrable claims.

### A. Indirect RICO Claims and Law of the Case

The law of the case doctrine "'posits that when a court decides upon a rule of law, that decision should continue to govern the same issues in subsequent stages in the same case.'" Christianson v. Colt Indus. Operating Corp., 486 U.S. 800, 816, 108 S. Ct. 2166, 2177 (1988) (citation omitted). This doctrine is designed to further important goals vital to just and efficient judicial process, including the provision of an end to litigation, the discouragement of "panel shopping," and the promotion of consistency in rulings between courts. Burger King Corp. v. Pilgrim's Pride Corp., 15 F.3d 166, 169 (11th Cir. 1994). The doctrine does not bar consideration of issues that could have been raised in a prior appeal but were not; however, the doctrine does apply not only as to "matters 'decided explicitly' but also as to those 'decided by necessary implication.'" DeLong Equip. Co. v. Washington Mills Electro Minerals Corp., 990 F.2d 1186, 1196 (11th Cir.) (citations omitted), modified on other grounds, 997 F.2d 1340 (11th Cir. 1993). The law of the case doctrine should guide a court in its discretion to hear subsequent appeals on a particular issue. See Arizona v. California, 460 U.S. 605, 618, 103 S. Ct. 1382, 1391 (1983). The doctrine, however, does not limit the court's power to revisit previously decided issues when (1) new and substantially different evidence emerges at a subsequent trial; (2) controlling authority has been rendered that is contrary to the previous decision; or (3) the earlier ruling was clearly

erroneous and would work a manifest injustice if implemented. Wheeler v. City of Pleasant Grove, 746 F.2d 1437, 1440 (11th Cir. 1984) (per curiam).

With these standards in mind, we must determine whether our prior decision constitutes law of the case as to indirect RICO claims and whether any of the Wheeler exceptions apply. First, HMOs argue that the district court and our court only decided that HMOs could not compel arbitration based on the contractual rights of third parties. Accordingly, they contend that we did not reach the issue of whether the indirect RICO claims actually did relate solely to the contractual rights of third parties. HMOs maintain that, rather than relating to third party contractual rights, the indirect RICO claims touch matters within the parties' arbitration agreements and therefore are arbitrable. Second, HMOs argue alternatively that even if the issue was previously reached, our prior opinion cannot be controlling law of the case because the amendment of the complaint, the addition of new defendants, and the decision in PacifiCare mandate we review our prior decision.

HMOs' first argument—that our previous decision did not reach the issue of the arbitrability of indirect RICO claims—is without merit. A review of our decision reveals that we affirmed two findings of the district court that bear on indirect RICO claims: (1) "that an HMO may not invoke its arbitration clause to compel arbitration of an aiding-and-abetting charge regarding a doctor's contractual rights with a different HMO . . . [and (2) that] an HMO that is not a signatory to a particular contract may not invoke that contract's arbitration clause to compel arbitration." In Re Humana Inc. Managed Care Litig., 285 F.3d at 973. After making this determination, we affirmed the district court's refusal to compel arbitration of indirect RICO claims. Id. at 977. Necessarily implicit in that ruling was a finding that indirect RICO claims did relate solely to third party

contractual rights. Moreover, we directly applied our decisions to the parties in several examples which also implied this finding. See id. at 973 nn. 4-5. Realizing that a prior decision is law of the case as to matters decided explicitly and by necessary implication, we find that our prior affirmation of the district court constitutes law of the case here and forecloses HMOs' argument that indirect RICO claims must be arbitrated.[5] See Burger King Corp., 15 F.3d at 169 (finding that prior decision allowing recovery of attorney's fees was law of the case by "necessary implication" which foreclosed subsequent appeal that the case was not sufficiently "exceptional" to award attorney's fees under Lanham Act); Terrell v. Household Goods Carriers' Bureau, 494 F.2d 16, 19 (5th Cir. 1974) (finding that law of case doctrine precluded review of causation issues where previous panel had affirmed liability which necessarily implied a finding on causation).

HMOs' alternative arguments—that an exception to the law of the case doctrine applies—are equally without merit. First, despite HMOs' allegations to the contrary, the district court found, and we agree, that physicians' amended complaint did not add anything new which would call into question our prior ruling regarding indirect RICO claims. See supra n.3. A review of the first and second amended complaints reveals that both contained the same basic allegations for the conspiracy and aiding and abetting claims; moreover, HMOs admit that the second amended complaint

---

[5] We note that while the law of the case doctrine does not bind nonparties, our prior decision does constitute precedent which we must follow in subsequent proceedings. See Morrow v. Dillard, 580 F.2d 1284, 1289 (5th Cir. 1978) (stating that a court's prior decision "establishes a precedent" which the court "will, normally, apply to the same issues in subsequent proceedings in the same case"). Thus, our prior decision regarding indirect RICO claims applies to both parties and nonparties to the original decision, under law of the case principles as to the former and under the rules of precedent as to the latter.

"clarified" physicians' position rather than fundamentally altering their claims. See id. Further, the addition of new parties did not substantially change the nature of the indirect RICO allegations. Accordingly, we reject HMOs' argument that the law of the case should be abandoned because new and substantially different evidence mandates a departure from the doctrine. See Louisville & Nashville R.R. Co. v. Higdon, 234 U.S. 592, 598-99, 34 S. Ct. 948, 950 (1914) (affirming refusal to allow subsequent appeal under the law of the case doctrine where an amended pleading "was simply an elaboration of the [pleading] presented" in an earlier appeal); De Tenorio v. Lightsey, 589 F.2d 911, 917 (5th Cir. 1979) (refusing to revisit prior findings because "plaintiff has presented nothing new in her amended complaint").[6] Second, contrary to HMOs' arguments, PacifiCare did not affect our previous ruling regarding indirect RICO claims because the Court only focused on whether remedial limitations in arbitration clauses prevented arbitration of direct RICO claims; the scope to be afforded arbitration agreements in the indirect RICO context was not before the Court. See supra n.2. Therefore, the exception that the law of the case doctrine is inapplicable when controlling authority controverts a prior decision does not apply here. See United States v. M.C.C. of Florida, Inc., 967 F.2d 1559, 1562 (11th Cir. 1992). Because none of the three exceptions to the law of the case doctrine listed in Wheeler apply, our prior decision regarding indirect RICO claims is controlling in this appeal.

---

[6] In a separate brief, adopted by the other HMOs, PacifiCare argues that the amendments to physicians' complaint mandate we reconsider our decision that the MS Dealer exception, which would allow an HMO that is a nonsignatory to an arbitration agreement with a physician to invoke that agreement to compel arbitration of a physician's claim against it, does not apply in this case. Because we find that the amended complaint does not allege anything new, that HMOs did not appeal our previous ruling on the MS Dealer issue, and that the Supreme Court's PacifiCare opinion did not affect our ruling, we reject PacifiCare's argument.

While not an inexorable command, the law of the case doctrine provides stability and finality in litigation, which are crucial cornerstone values for developing a just and efficient judicial process. Litman v. Massachusetts Mut. Life Ins. Co., 825 F.2d 1506, 1511 (11th Cir. 1987). Here, we previously decided, if not explicitly then by necessary implication, that HMOs may not compel arbitration of physicians' indirect RICO claims. HMOs' failure to seek en banc review or certiorari with respect to these issues caused our previous ruling to become law of the case. See Silverberg v. Paine, Webber, Jackson & Curtis, Inc., 724 F.2d 1456, 1457 (11th Cir. 1983) (per curiam). Because HMOs have failed to show that an exception mandates our departure from the law of the case doctrine, we cannot reconsider our previous ruling.[7] Accordingly, the district court properly held that the law of the case doctrine precludes reconsideration of our previous determination that HMOs cannot compel physicians to arbitrate their indirect RICO claims.

B. District Court's Refusal to Compel Arbitration

We review a district court's denial of a motion to compel arbitration de novo. Musnik v. King Motor Co. of Fort Lauderdale, 325 F.3d 1255, 1257 (11th Cir. 2003). The determination of the propriety of a motion to compel arbitration pursuant to Section 4 of the Federal Arbitration Act (FAA)[8] is a two-step inquiry. The first step is to determine whether the parties agreed to arbitrate the dispute. Mitsubishi

---

[7] Absent an erroneous ruling that would work manifest injustice, consistency between appellate panels is mandated even if a subsequent panel would have decided a case differently than the prior panel. See United States v. Burns, 662 F.2d 1378,1384 (11th Cir. 1981).

[8] U.S.C. § 4 (2004). The Act provides that "[a] party aggrieved by the alleged failure, neglect, or refusal of another to arbitrate under a written agreement for arbitration may petition any United States district court . . . for an order directing that such arbitration proceed in the manner provided for in such agreement." Id.

Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614, 626, 105 S. Ct. 3346, 3353 (1985). We must make this determination "by applying the 'federal substantive law of arbitrability, applicable to any arbitration agreement within the coverage of the [FAA].'"[9] Id. (citation omitted). This inquiry must be undertaken against the background of a "liberal federal policy favoring arbitration agreements." Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp., 460 U.S. 1, 24, 103 S. Ct. 927, 941 (1983) ("[Q]uestions of arbitrability must be addressed with a healthy regard for the federal policy favoring arbitration."). Under this policy, it is the role of courts to "rigorously enforce agreements to arbitrate." Dean Witter Reynolds, Inc. v. Byrd, 470 U.S. 213, 221, 105 S. Ct. 1238, 1242 (1985). Because arbitration is a matter of contract, however, the FAA's strong proarbitration policy only applies to disputes that the parties have agreed to arbitrate. Mastrobuono v. Shearson Lehman Hutton, Inc.,514 U.S. 52, 57, 115 S. Ct. 1212, 1216 (1995). In the absence of an agreement to arbitrate, a court cannot compel the parties to settle their dispute in an arbitral forum. See AT&T Techs., Inc. v. Communications Workers of Am., 475 U.S. 643, 648, 106 S. Ct. 1415, 1418 (1986) (citation omitted); see Volt Info. Sci., Inc. v. Bd. of Tr. of Leland Stanford Junior Univ., 489 U.S. 468, 479, 109 S. Ct. 1248, 1256 ("Arbitration under the [FAA] is a matter of consent, not coercion . . . . "). The second step in ruling on a motion to compel arbitration involves deciding whether "legal constraints external to the

---

[9] The FAA applies to any contract "affecting" interstate commerce. Allied-Bruce Terminix Cos. v. Dobson, 513 U.S. 265, 273-74, 115 S. Ct. 834, 839 (1995); see 9 U.S.C. § 2 (FAA covers any "contract evidencing a transaction involving commerce"). It is undisputed that the contracts at issue in this case affect interstate commerce and that the precedent construing the FAA applies.

parties' agreement foreclosed arbitration." Mitsubishi Motors Corp., 473 U.S. at 628, 105 S. Ct. at 3355.[10]

1. Non-Par Claims

With these general principles in mind, we turn to the district court's ruling that non-par claims are only arbitrable if: (1) the physician asserting the non-par claim has a contract containing an arbitration clause with the target HMO that covers the rendering of services from which the claim arose; or (2) the physician was assigned a claim for reimbursement by a patient who has a contract with the target HMO. First, HMOs argue that the broad arbitration clauses[11] signed by physicians are sufficient to cover any non-par claims brought by physicians, even if the contract they signed does not cover the rendition of services from which the claim arose. Second, HMOs argue that all of physicians' non-par claims, even those the district court exempted from arbitration as claims held by the physicians in their own right,[12] are derivative of a patient-subscriber's contract and therefore arbitrable. We will address each argument in turn.

---

[10] Because the parties dispute only the scope of the arbitration agreements and not their enforceability, we will not discuss this second step of the analysis.

[11] "While the contracts signed between physicians (and patients) and HMOs vary in their particular terms, they have in common the substance of broadly worded arbitration clauses. For example, PacifiCare sought to compel arbitration based on a contract which called for arbitration of "any controversy, dispute, or claim arising out of the agreement." See In Re Managed Care Litig., 132 F. Supp. 2d at 1005. Because we find that even the broadest arbitration clauses could not compel arbitration of non-par claims in this instance, we need not parse through the language used in each HMO's arbitration agreements.

[12] The district court held that physicians' claims which arose under quasi-contractual theories were not arbitrable because the claims belonged to the physicians in their own right and not on the basis of an assignment.

First, HMOs' attempt to expand the scope of various arbitration agreements to cover the rendition of services outside of the services contemplated by a particular contract is ineffectual. Because arbitration can only be compelled when the subject of the dispute has been agreed to be settled by arbitration, having one contract which contains a broad arbitration agreement does not necessarily mean that arbitration can be compelled when the subject of the dispute arises from a separate contract which does not have an arbitration clause. Seaboard Coast Line R.R. Co. v. Trailer Train Co., 690 F.2d 1343, 1352 (11th Cir. 1982) (refusing to compel arbitration based on broad arbitration clause found in a license contract between the parties when the underlying claim was for breach of a separate lease contract which did not contain an arbitration clause). While we acknowledge that any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration, see Moses H. Cone Mem'l Hosp., 460 U.S. at 24-25, 103 S. Ct. at 941, no doubt has been cast upon whether physicians agreed to arbitrate non-par claims; it is undisputed that physicians did not sign contracts containing arbitration clauses for the provision of the services from which the non-par claims have sprung. In effect, physicians are nonsignatories of arbitration agreements with respect to these non-par claims and yet HMOs are attempting to compel arbitration as if they were signatories. Implicit in our previous decision was a rejection of this argument. See In Re Humana Inc. Managed Care Litig., 285 F.3d at 973 (finding that "an HMO that is not a signatory to a particular contract may not invoke that contract's arbitration clause to compel arbitration"). Moreover, HMOs drafted the arbitration agreements signed by the physicians with whom they have contracts and represented to physicians without contracts that they would be compensated for providing out-of-network services. If HMOs wanted the benefit of arbitration for disputes arising from non-par claims, they could have contracted with physicians for it. See Mastro-

buono, 514 U.S. at 62-63, 115 S. Ct. at 1219 (construing scope of arbitration agreement against the party that initiated the contract). Arbitration is at its core a matter of contract, and here it is clear that physicians did not agree to arbitrate these non-par claims. See EEOC v. Waffle House, Inc., 534 U.S. 279, 294, 122 S. Ct. 754, 764 (2002). Accordingly, the district court properly refused to compel arbitration of non-par claims asserted by physicians based on arbitration agreements they had signed regarding the provision of services unrelated to the non-par claims.

HMOs' second argument—that the district court should have compelled arbitration of non-par claims asserted by physicians under quasi-contract and statutory causes of action because these claims stemmed from claims assigned to them by patient-subscribers who bad signed arbitration agreements—fails on similar grounds. Because physicians asserting non-par claims do not have a contractual relationship with the HMO, they can only be compelled to arbitrate non-par claims to the extent that they received the right to reimbursement by assignment from patient-subscribers who had signed arbitration agreements. See DiMercurio v. Sphere Drake Ins. PLC, 202 F.3d 71, 81(1st Cir. 2000). However, as with the non-par claims for services rendered outside of the contractual relationship established between physicians and HMOs, the non-par claims asserted by physicians under quasi-contract and statutory theories necessarily stem from services rendered outside of the contracts established between patient-subscribers and HMOs. [13] Because these claims are

[13] If the services rendered were covered by the contract between patient-subscriber and the HMO, then the physicians' claims would be arbitrable under the district court's order that "any claims that necessarily rely upon subscriber contracts with arbitration clauses must be arbitrated." In Re Managed Care Litig., __ F. Supp. 2d at __. HMOs, however, have represented that physicians will be reimbursed for supplying medically necessary treatments to patient-subscribers even if such treatments are not covered by contract. Thus, because the physicians' non-par claims in this

thus held by physicians independent of the patient-subscriber contracts, HMOs may not argue that the scope of the arbitration agreements in the patient-subscriber contracts should be extended to compel arbitration. See American Bankers Ins. Co. of Fla. v. First State Ins. Co., 891 F.2d 882, 885 (11th Cir. 1990) (per curiam) (finding unjust enrichment claims existed independently of contractual claims). Thus, the district court properly found nonarbitrable non-par claims asserted by physicians under quasi-contract and statutory causes of action in the absence of an assignment from a patient-subscriber who had signed an arbitration agreement.

2. Medical Association Claims

HMOs also argue that the district court erred by refusing to compel arbitration of the indirect RICO and non-par claims brought by medical association plaintiffs on behalf of some of their members. Specifically, as they argued regarding physicians' attempt to litigate these claims, HMOs argue that these claims brought by the medical associations are within the scope of the various arbitration agreements signed by the associations' members or their patient-subscribers who have assigned reimbursement claims to their members. Because associations suing in a representative capacity are bound by the same limitations and obligations as their members, see Arizonans for Official English v. Arizona, 520 U.S. 43, 65-66, 117 S. Ct. 1055, 1068 (1997), our previous discussion regarding the scope to be afforded to arbitration agreements with respect to these claims is controlling. Accordingly, we reject HMOs' arguments to the extent that they are inconsistent with our previous determinations of the scope to

---

instance are not based on any contract to provide the particular treatments, quasi-contract and statutory theories are the physicians' only recourse to recover for these services. See Flint v. ABB, Inc., 337 F.3d 1326, 1331 n.2 (11th Cir. 2003) (explaining that quasi-contract claims are the only claims available in the absence of a specific contractual obligation to perform services) cert. denied, __ U.S. __, 124 S. Ct. 1507 (2004).

be given to arbitration agreements as they impact indirect RICO and non-par claims.

3. Claims Outside of the Effective Dates of the Arbitration Agreements

HMOs also argue that the district court erred by refusing to compel arbitration of disputes which arose outside of the effective dates of the contracts containing arbitration agreements. Specifically, HMOs argue that our decision in Belke v. Merrill Lynch, Pierce, Fenner & Smith, 693 F.2d 1023, 1028 (11th Cir. 1982) compels us to order arbitration even for claims which arose either before or after the execution of arbitration agreements.[14] We disagree. Our decision in Armada Coal Exp., Inc. v. Interbulk, Ltd., 726 F.2d 1566, 1567-68 (11th Cir. 1984), in which we refused to compel arbitration of claims that arose after a contract with a valid arbitration agreement had been breached, demonstrated that Belke did not categorically command the arbitration of claims arising from disputes outside of the effective dates of arbitration agreements. Moreover, the Supreme Court has since found in the collective bargaining context that arbitration cannot be mandated for a grievance which arose after the expiration of an arbitration agreement even when the parties bargained for a "broad arbitration provision." Litton Fin. Printing Div. v. NLRB, 501 U.S. 190, 193-201, 111 S. Ct. 2215, 2219-2223 (1991); see District No. 1 - Marine Eng'rs Beneficial Ass'n v. GFC Crane Consultants, Inc., 331 F.3d 1287, 1291 (11th Cir. 2003) (noting that "grievance

[14] HMOs argue alternatively that the question of the temporal scope to be afforded to arbitration agreements should be a matter decided by an arbitrator in the first instance. In essence, both parties dispute whether they in fact agreed to arbitrate disputes which arose either before or after the effective dates of the arbitration agreements. Because such questions of arbitrability are "undeniably an issue for judicial determination," we reject HMOs' argument that an arbitrator should decide the temporal scope issue. AT&T Techs., Inc., 475 U.S. at 649, 106 S. Ct. at 1418.

arbitration obligations end upon expiration of the CBA unless the parties have agreed otherwise"). Because arbitration is strictly a matter of contract, we cannot compel arbitration for disputes which arose during time periods in which no effective contract requiring arbitration was governing the parties. See Brandon, Jones, Sandall, Zeide, Kohn, Chalal & Musso, P.A. v. MedPartners, Inc., 312 F.3d 1349, 1358 (11th Cir. 2002) (per curiam) ("[W]e will compel no arbitration of issues that are outside an agreement to arbitrate."). Accordingly, the district court properly refused to compel arbitration of claims arising from disputes which arose outside of the effective dates of arbitration agreements.

C. District Court's Refusal to Grant a Stay

We review a district court's denial of a motion to stay litigation of nonarbitrable claims under an abuse of discretion standard. See Moses H. Cone Mem'l Hosp., 460 U.S. at 21 n.23, 103 S. Ct. at 939 n.23; Sam Reisfeld & Son Import Co. v. S. A. Eteco, 530 F.2d 679, 681 (5th Cir. 1976). Pursuant to Section 3 of the FAA, a district court shall stay a pending suit "upon being satisfied that the issue involved in such suit or proceeding is referable to arbitration" under a valid arbitration agreement. 9 U.S.C. § 3. For arbitrable issues, the language of Section 3 indicates that the stay is mandatory. See Shearson/Am. Express, Inc. v. McMahon, 482 U.S. 220, 226, 107 S. Ct. 2332, 2337 (1987) ("[A] court must stay its proceedings if it is satisfied that an issue before it is arbitrable. . . . ") (emphasis added). When confronted with litigants advancing both arbitrable and nonarbitrable claims, however, courts have discretion to stay nonarbitrable claims. See Moses H. Cone Mem'l Hosp., 460 U.S. at 21 n.23, 103 S. Ct. at 939 n.23; AgGrow Oils, L.L.C., v. Nat'l Union Fire Ins. Co. of Pittsburgh, 242 F.3d 777, 782-83 (8th Cir. 2001); Sam Reisfeld & Son Import Co., 530 F.2d at 681. In this instance, courts generally refuse to stay proceedings of nonarbitrable claims when it is feasible to proceed with the litigation. See

Dean Witter Reynolds Inc., 470 U.S. at 225, 105 S. Ct. at 1245 (White, J., concurring) (noting that the "heavy presumption should be that the arbitration and the lawsuit will each proceed in its normal course"). Crucial to this determination is whether arbitrable claims predominate or whether the outcome of the nonarbitrable claims will depend upon the arbitrator's decision. See Genesco, Inc. v. T. Kakiuchi & Co., Ltd., 815 F.2d 840, 856 (2d Cir. 1987).

Here, the district court found that it would be feasible to compel arbitration of arbitrable claims while allowing litigation of nonarbitrable claims. The district court stated that its refusal to grant the stay would not result in duplicative proceedings and would not permit a decision in either proceeding to have preclusive effect in the other. Moreover, the district court did not find that physicians were predominately advancing arbitrable claims. In fact, at oral argument, it was disputed whether any arbitrable claims remained before the district court which physicians had not dismissed.[15] Because it is well established that a district court may order arbitration and refuse to stay nonarbitrable proceedings, the district court was properly within its discretion to refuse HMOs' motion to stay litigation of nonarbitrable claims. See Dean Witter Reynolds Inc., 470 U.S. at 221, 105 S. Ct. at 1243 (stating that proper enforcement of FAA might yield "piecemeal" litigation); Moses H. Cone Mem'l Hosp., 460 U.S. at 20, 105 S. Ct. at 939 (finding that district court may order the parties to resolve "related disputes in different forums").

---

[15] To the extent that claims deemed arbitrable have not been dismissed, we affirm the district court's order that the litigation of arbitrable claims must be stayed and that arbitration of these claims must be compelled. Shearson/Am. Express, Inc., 482 U.S. at 226, 107 S. Ct. at 2337.

## III. CONCLUSION

In this appeal involving both signatories and nonsignatories of broad arbitration agreements, HMOs argued that the district court erred by refusing to compel arbitration and stay litigation based on an expansive interpretation of the arbitration agreements and the strong federal policy favoring arbitration. As we have explained, however, the law of the case doctrine precluded us from revisiting our previous rulings regarding indirect RICO claims and the federal policy favoring arbitration could not compel us to order arbitration of disputes which the parties had not agreed to arbitrate. Accordingly, the district court's order is

**AFFIRMED.**

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE ELEVENTH CIRCU**

[Filed Janu.. y 7, 2005]

---

No. 03-14828-CC

---

LEONARD J. KLAY, M.D., ALL PLAINTIFFS, PRICE PLAINTIFFS, PRICE, SESSA, KATZ & YINGLING, SANDRA JOHNSON, PATRICIA FREYRE, et al.,
Plaintiffs-Appellees,

REGINA JOI PRICE, et al.,
Plaintiffs,

versus

ALL DEFENDANTS, et al.,
Defendants,

PACIFICARE HEALTH SYSTEMS, INC., HUMANA, INC., COVENTRY HEALTH CARE, INC., ANTHEM HEALTH PLANS, INC., PRUDENTIAL INSURANCE COMPANY OF AMERICA, UNITED HEALTHCARE, UNITED HEALTH GROUP, HUMANA HEALTH PLAN, INC., WELLPOINT HEALTH NETWORKS, INC.,
Defendants-Appellants.

---

On Appeal from the United States District Court for the Southern District of Florida

---

ON PETITION(S) FOR REHEARING AND PETITION(S) FOR REHEARING EN BANC (Opinion _____, 11th Cir., 19__, ____F.2d____).

Before: ANDERSON and BIRCH, Circuit Judges, and LAND*, Circuit Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

s/Stanley F. Birch, Jr.
UNITED STATES CIRCUIT JUDGE

ORD-42
(12/01)

* Honorable Clay D. Land, United States District Judge for the Middle District of Georgia, sitting by designation.

UNITED STATES CODE
TITLE 18. CRIMES AND CRIMINAL PROCEDURE
PART I—CRIMES
CHAPTER 1—GENERAL PROVISIONS

§2. Principals

(a) Whoever commits an offense against the United States or aids, abets, counsels, commands, induces or procures its commission, is punishable as a principal.

(b) Whoever willfully causes an act to be done which if directly performed by him or another would be an offense against the United States, is punishable as a principal.

# UNITED STATES CODE
# TITLE 18. CRIMES AND CRIMINAL PROCEDURE
# PART I—CRIMES
# CHAPTER 96—RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS

## §1961. Definitions

As used in this chapter—

(1) "racketeering activity" means (A) any act or threat involving murder, kidnapping, gambling, arson, robbery, bribery, extortion, dealing in obscene matter, or dealing in a controlled substance or listed chemical (as defined in section 102 of the Controlled Substances Act), which is chargeable under State law and punishable by imprisonment for more than one year; (B) any act which is indictable under any of the following provisions of title 18, United States Code: Section 201 (relating to bribery), section 224 (relating to sports bribery), sections 471, 472, and 473 (relating to counterfeiting), section 659 (relating to theft from interstate shipment) if the act indictable under section 659 is felonious, section 664 (relating to embezzlement from pension and welfare funds), sections 891-894 (relating to extortionate credit transactions), section 1028 (relating to fraud and related activity in connection with identification documents), section 1029 (relating to fraud and related activity in connection with access devices), section 1084 (relating to the transmission of gambling information), section 1341 (relating to mail fraud), section 1343 (relating to wire fraud), section 1344 (relating to financial institution fraud), section 1425 (relating to the procurement of citizenship or nationalization unlawfully), section 1426 (relating to the reproduction of naturalization or citizenship papers), section 1427 (relating to the sale of naturalization or citizenship papers), sections 1461-1465 (relating to obscene matter), section 1503 (relating to obstruction of justice), section 1510 (relating to obstruction

of criminal investigations), section 1511 (relating to the obstruction of State or local law enforcement), section 1512 (relating to tampering with a witness, victim, or an informant), section 1513 (relating to retaliating against a witness, victim, or an informant), section 1542 (relating to false statement in application and use of passport), section 1543 (relating to forgery or false use of passport), section 1544 (relating to misuse of passport), section 1546 (relating to fraud and misuse of visas, permits, and other documents), sections 1581-1591 (relating to peonage, slavery, and trafficking in persons), section 1951 (relating to interference with commerce, robbery, or extortion), section 1952 (relating to racketeering), section 1953 (relating to interstate transportation of wagering paraphernalia), section 1954 (relating to unlawful welfare fund payments), section 1955 (relating to the prohibition of illegal gambling businesses), section 1956 (relating to the laundering of monetary instruments), section 1957 (relating to engaging in monetary transactions in property derived from specified unlawful activity), section 1958 (relating to use of interstate commerce facilities in the commission of murder-for-hire), sections 2251, 2251A, 2252, and 2260 (relating to sexual exploitation of children), sections 2312 and 2313 (relating to interstate transportation of stolen motor vehicles), sections 2314 and 2315 (relating to interstate transportation of stolen property), section 2318 (relating to trafficking in counterfeit labels for phonorecords, computer programs or computer program documentation or packaging and copies of motion pictures or other audiovisual works), section 2319 (relating to criminal infringement of a copyright), section 2319A (relating to unauthorized fixation of and trafficking in sound recordings and music videos of live musical performances), section 2320 (relating to trafficking in goods or services bearing counterfeit marks), section 2321 (relating to trafficking in certain motor vehicles or motor vehicle parts), sections 2341-2346 (relating to trafficking in contraband cigarettes), sections 2421-24 (relating to white

slave traffic), (C) any act which is indictable under title 29, United States Code, section 186 (dealing with restrictions on payments and loans to labor organizations) or section 501(c) (relating to embezzlement from union funds), (D) any offense involving fraud connected with a case under title 11 (except a case under section 157 of this title), fraud in the sale of securities, or the felonious manufacture, importation, receiving, concealment, buying, selling, or otherwise dealing in a controlled substance or listed chemical (as defined in section 102 of the Controlled Substances Act), punishable under any law of the United States, (E) any act which is indictable under the Currency and Foreign Transactions Reporting Act, (F) any act which is indictable under the Immigration and Nationality Act, section 274 (relating to bringing in and harboring certain aliens), section 277 (relating to aiding or assisting certain aliens to enter the United States), or section 278 (relating to importation of alien for immoral purpose) if the act indictable under such section of such Act was committed for the purpose of financial gain, or (G) any act that is indictable under any provision listed in section 2332b(g)(5)(B);

(2) "State" means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, any political subdivision, or any department, agency, or instrumentality thereof;

(3) "person" includes any individual or entity capable of holding a legal or beneficial interest in property;

(4) "enterprise" includes any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity;

(5) "pattern of racketeering activity" requires at least two acts of racketeering activity, one of which occurred after the

effective date of this chapter and the last of which occurred within ten years (excluding any period of imprisonment) after the commission of a prior act of racketeering activity;

(6) "unlawful debt" means a debt (A) incurred or contracted in gambling activity which was in violation of the law of the United States, a State or political subdivision thereof, or which is unenforceable under State or Federal law in whole or in part as to principal or interest because of the laws relating to usury, and (B) which was incurred in connection with the business of gambling in violation of the law of the United States, a State or political subdivision thereof, or the business of lending money or a thing of value at a rate usurious under State or Federal law, where the usurious rate is at least twice the enforceable rate;

(7) "racketeering investigator" means any attorney or investigator so designated by the Attorney General and charged with the duty of enforcing or carrying into effect this chapter;

(8) "racketeering investigation" means any inquiry conducted by any racketeering investigator for the purpose of ascertaining whether any person has been involved in any violation of this chapter or of any final order, judgment, or decree of any court of the United States, duly entered in any case or proceeding arising under this chapter;

(9) "documentary material" includes any book, paper, document, record, recording, or other material; and

(10) "Attorney General" includes the Attorney General of the United States, the Deputy Attorney General of the United States, the Associate Attorney General of the United States, any Assistant Attorney General of the United States, or any employee of the Department of Justice or any employee of any department or agency of the United States so designated by the Attorney General to carry out the powers conferred on the Attorney General by this chapter. Any department or

agency so designated may use in investigations authorized by this chapter either the investigative provisions of this chapter or the investigative power of such department or agency otherwise conferred by law.

# UNITED STATES CODE
# TITLE 18. CRIMES AND CRIMINAL PROCEDURE
# PART I—CRIMES
# CHAPTER 96—RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS

## §1962. Prohibited activities

(a) It shall be unlawful for any person who has received any income derived, directly or indirectly, from a pattern of racketeering activity or through collection of an unlawful debt in which such person has participated as a principal within the meaning of section 2, title 18, United States Code, to use or invest, directly or indirectly, any part of such income, or the proceeds of such income, in acquisition of any interest in, or the establishment or operation of, any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce. A purchase of securities on the open market for purposes of investment, and without the intention of controlling or participating in the control of the issuer, or of assisting another to do so, shall not be unlawful under this subsection if the securities of the issuer held by the purchaser, the members of his immediate family, and his or their accomplices in any pattern or racketeering activity or the collection of an unlawful debt after such purchase do not amount in the aggregate to one percent of the outstanding securities of any one class, and do not confer, either in law or in fact, the power to elect one or more directors of the issuer.

(b) It shall be unlawful for any person through a pattern of racketeering activity or through collection of an unlawful debt to acquire or maintain, directly or indirectly, any interest in or control of any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce.

(c) It shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or

participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt.

(d) It shall be unlawful for any person to conspire to violate any of the provisions of subsection (a), (b), or (c) of this section.